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AUTHOR Perkins, Stanley A.
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ABSTRACT

The paper reviews factors which interfere with normal socialization of young handicapped children, and considers such issues as dependency, sex role, socialization within the family, and sibling and peer relationships. The role of preschool programs in intervening in the young handicapped child's socialization is examined. (CL)

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SOCIALIZATION OF THE HANDICAPPED CHILD

by

Dr. Stanley A. Perkins

University of British Columbia

Canada

A handicapped child has to face many unique and complex developmental tasks in addition to the usual ones encountered by the child in adjusting to himself, to his handicapped condition and to his immediate world around him. The effects of a handicap influence all aspects of a child's growth and development. The handicapped child does not experience a normal course of human interaction and socialization.

The handicapped child is prevented from experiencing normal socialization because of the physiological limitations inherent in his condition -- it may be an extremely poor sensory condition (deaf or blind), or it may be poor mobility (crippled) -- and psychological and social limitations which have an inhibiting effect on the child himself. In addition, the negative reactions by the non-handicapped to the child with a handicap play an important part, because the handicapped child may have a different appearance and behaviour from his peers. (Battle 1974)

Traditionally the study of the handicapped child has been subdivided into categories, but the current emphasis has changed this. The greater awareness that many handicapped children are in fact multiply handicapped has tended to individualize the study of the handicapped child. There is now concern that each child is a unique person with his own handicaps and his own problems in coping with the daily demands of the world.

Many of the problems faced by the handicapped are common to people with different types of handicaps. The prejudice they face and the sympathy they receive are not fundamentally different for the blind

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or the crippled person who walks with the aid of braces and crutches. The reaction of a handicapped child who is overprotected by his mother is not so different from the reaction of any child in an overprotected environment. (Baldwin and Baldwin, 1976)

Susser and Walton (1971) distinguished three components of handicap: organic, functional, and social. Impairment is the organic component, a static condition of the process of disease. Disability is the functional component, or the limitation of function imposed by impairment and the individual's psychological reaction to it. Handicap is the social component, the manner and degree in which the primary impairment and functional disability limit the performance of social roles and relations with others. It is this latter component which is the focus of this paper. The author will review selected aspects of the factors which interfere with normal socialization in the early years of the handicapped child.

Socialization.

As defined by English and English (1973), socialization is

> "the process whereby a person (especially a child) acquires sensitivity to social stimuli (especially the pressures and obligations of group life) and learns to get along with, and behave like, others in his group or culture: the process of becoming a social being."

Mechanisms of Socialization.

Kagan (1971) presents a fuller definition of socialization indicating in detail which behaviours are valued and socialized. He notes that the major mechanisms of socialization are similar for all cultures, though the emphasis across cultures differs. Each of the four mechanisms -- desire for reward, fear of punishment, identification, and imitation -- is strongest at different periods of development and facilitates different aspects of the socialization process. Kagan believes that good values and beliefs are likely to be acquired by

identification with a desirable model. Identification is the process of the child's wishing to be similar to a particular person whom he has grown to respect, love and admire.

According to McCandless (1969) there are five aspects of human behaviour in the normal young child that must be socialized after the first year of life: feeding and weaning, toileting and elimination, sex needs and practices, aggression needs and practices and lastly dependency needs and behaviour. Some of these aspects cannot be socialized in the normal way in the handicapped child because his body structure and its functions are not normal. It may be that he cannot suck, swallow or chew very well. It may be that he cannot sit up or walk; that he cannot explore his environment in the normal manner because he is not mobile or is blind. It may be that he is unable to learn his sex role through normal play and imitation; that he is unable to handle his own bathroom needs and that he must remain dependent on others for help in most areas of his daily life.

Social adaptation results from being able to satisfy the need to explore one's environment. The child who is severely physically disabled (cerebral palsy) can never fully satisfy the need to explore. This limits his acquisition of knowledge and his achievement of independence, and it limits his pleasures.

Bruner cites three modes of interaction with the environment and McCandless (1969) believes that the individual must have mastered all three methods. The first mode of interaction with the environment involves the "near receptors" -- the how to do it mechanisms -- the hands. Secondly, the individual must consolidate his "distance receptors" -- vision, hearing, motor, mental -- and learn how to perceive, coordinate and anticipate. Thirdly, the individual must master the symbolic system of the environment -- language. These three socialization mechanisms have implications for the development of the handicapped child. If he has cerebral palsy then he cannot interact with his environment by using his hands as a normal child would as his hands will not go where he wants them to go. He may have to make

his contact through his eyes. But if he also has a vision problem, he may perceive the world in unusual ways. Such a cerebral palsied child would not be able to interact with the environment effectively as could a normal child. His incapacity would not permit him to master the three necessary modes. All three modes of interaction with the environment may be partially unattainable for the handicapped child.

Dependency.

All children are very dependent in their early years. This is usually recognized by immediate, generous and consistent rewards for all their demands. In this way, a climate of trust is established. On the other hand, this dependence must be reduced later by reinforcing independent behaviour at the risk and fear of losing parental love and support. The child, however, must achieve independence in order to live a satisfying adult life. Through highly selective reinforcement, parents can help their children toward independent behaviour by seeking the influence of others such as peers. Unfortunately, parents of normal children can also reinforce dependency behaviour -- such as crying, etc.

Scott (1969) argues that institutions for the handicapped cause the individual to be dependent in return for financial and other help. A similar phenomenon may occur early within the family of a handicapped child. In other words, an individual is taught or conditioned to be dependent.

Sex Role.

A key factor in the socialization of the child is the individual's sex role. Through psychological identification with the parent of the same sex and by imitation of that parent through play, the child comes to learn his or her sex role. At the same time, the child models himself in many ways after the parent of the opposite sex. Since a handicapped child's impairment may prevent him from role playing and limit imitation opportunities, it is difficult for him or her to achieve complete awareness of himself/herself as a boy or girl.

Social Learning.

Another viewpoint held by social psychologists is that social

learning occurs independently of any active imitation opportunities. Bandura (1965) suggests that a handicapped child may learn despite the inability to role play like a normal child. A person who exhibits snake phobias may never have had a direct experience with reptiles. Such evidence of 'no trial learning' is useful to keep in mind when working with the handicapped child.

Socialization within the Family.

The infant is socialized and his behaviour is modified by whatever social encounters he has. If he is a first born, normal infant, he socializes his parents in two obvious ways: He causes a rearrangement of the family home, and a rearrangement of the parents' psychological world. The parents have hopes and aspirations for their child's future. When the child is handicapped, the parents' psychological extension in the child is thwarted.

The normal infant's most powerful socializers are his smile, his cry, and to a lesser extent, his vocalizations. The smile pleases his parents, but the cry has been called a social signal by which the child ensures his own survival. The handicapped infant may remain restricted to these three socializers much longer than a normal child. The result is stress and strain on the parents and siblings.

Family.

When a handicapped child is added to a family, a new family unit is formed which requires difficult adjustments on the part of parents and siblings, if there are any other children. On being faced with a handicapped child, parents go through several stages. Boyd (1959) has outlined the stages of recognition as follows: First, denial that a problem exists; second, self pity for themselves, followed by pity for the child; and finally, hopefully, an accommodation with the situation and concern for the well-being of all handicapped children.

In order to cope with the stressful situation, the parents develop various strategies. Reality testing is a strategy where parents observe the child's capabilities and limitations in a wide variety of

situations and readjust their expectations of the child accordingly. Correction is a strategy where adjustments are made through education or corrective devices to minimize or eliminate the disability. Other techniques used by parents are: overprotection, isolation, and rejection of the child. In its extreme form, rejection leads to institutionalization. Alterations occur in the family roles. For example, siblings, particularly the sisters, are cast in a parent-sharing role. (Farber, 1968)

Effect on the Family.

The presence of a handicapped child in the family influences a wide variety of family interactions. The general effect is adverse for family functioning. A study by Fotheringham, Shelton and Hoddinott (1971, 1972) evaluated the impact of a retarded child on a family by observing the effect of removal of the child to an institution in one group of 80 families, compared with another group of 38 families with children of comparable age, sex and mental age, who remained at home during the year of the study. The results showed that the community group had deteriorated in a number of categories, except home and household practices, economic practices, and social activities.

Farber and Ryckman (1965) and Farber (1968) both present evidence of the adverse effect of the retarded child on marital integration, social activities, job promotion, and on family roles and sibling occupational expectancy. These studies demonstrate that the presence of a handicapped child in a family results in a reduction in the family's functioning, and thus the families themselves may be described as being disabled rather than just handicapped. A reduction in family functioning, however, is not the invariable consequence of the presence of a handicapped child.

Family Effects on the Handicapped Child.

The child's eventual social competance is the end result of the interaction of his primary handicap with his physical and social environment. Since the family is the major social influence on the child in his early years, the type of home situation in which the handicapped child resides may well provide the conditions to produce

the necessary improvement in social competence. A number of studies demonstrate a strong relationship between home circumstances and a child's achievement.

Birch and Gussow, (1970) document the relationship between poor health and nutrition and school failure.

The willingness of the child to imitate parental behaviour and language, and to respond to social reinforcement, is dependent on a satisfactory affectional bond between parents and child. Ralph, Goldberg and Passow (1966) reviewed studies demonstrating a relationship between family emotional climate and underachievement. Gardner (1972) reports the effect of an emotionally deprived home on a child's physical development. A study done in Ontario in 1974 by Fotheringham also showed that socioeconomic status plus home ratings correlated highly with the child's achievement.

Siblings and Peers.

Problems of sibling rivalry may arise within the family because the parents are not consistent with their expected standards of behaviour for all siblings. The parents face the problem of how to praise the normal child without hurting the feelings of the handicapped child and making him feel "different" or inadequate. Interactions caused by rivalry disrupt the family unity and retard the social development of the handicapped child.

Peers play a powerful part in the social development of the handicapped child. The peer group is irreplaceable in role rehearsal, dimensions of cooperative and competitive behaviour, expression of aggression and dependency. From his peers the handicapped child gains important confirmation-disconfirmation of self judgments of competance of self-esteem. Without a peer group, a child is deprived of this aspect of the socialization process.

With current emphasis on integration in preschool programs, concern has been expressed that non-handicapped children will imitate their handicapped peers. A study by Peterson, Peterson and Scriven (1977) shows that the non-handicapped did not imitate their handicapped peers.

Pre-School Parent Oriented Programs.

With the emphasis by Bloom (1964) that a major proportion of intelligence is developed in the early years, and that an appropriate social environment is necessary for the child to develop that intelligence, much research in innovative programming has been implemented recently, particularly programs involving the parents. This concept is based on work done by Skeels (1942). Skeels removed from an orphanage thirteen children all under three years of age, and placed them either singly or in pairs in wards in a residential center for mildly retarded adolescent or adult females. The mean IQ of the experimental group was 64.3 and the mean IQ of the control group of twelve children also under three years of age was 86.7. It was assumed that the residential center environment would be more stimulating than that of the orphanage. After two years of treatment, the mean IQ of the experimental group was 91.8, and after a further two and a half years 95.9, and overall gain of 31.6. The mean IQ of the control group decreased from 86.7 to 60.5 at the close of the experiment, and then increased to 66.1 on the follow-up two and a half years later, and overall loss of 20.1

Recent Programs.

A limited number of selected recent early intervention programs involving parents will be reviewed.

Levenstein (1971) studied the use of professional home visitors who acted as toy demonstrators and who trained mothers in the home by semi-weekly visitations over a seven month period. The mean IQ gain of both the two and three year old experimental groups was 17 points, while the control groups remained unchanged. Later, when the training of mothers was implemented by a non-professional staff, similar results were obtained.

Fowler (1972) describes a program in Canada which involved early intervention in a day care setting including parent education. Children admitted to the program with a mean age of 10 months gained 20 IQ points whereas children admitted to the program with a mean age of 19 months

gained 6-10 points. Fowler concludes that stimulation programs should begin at or before one year of age.

Heber and Garber (1970) developed The Milwaukee Project--a program designed to reduce mental retardation through early intervention with black mothers of 70 IQ and below and their children. Occupational training, home care, baby care was proveded the mother shortly after she returned home from hospital. At three months the child was taken to a center to participate in a program which emphasized sensory and language stimulation designed to facilitate achievement motivation, problem solving skills, and language development. Initially, the staff ratio was 1 to 1, but as the children became older, it increased to 1 to 5. At 42 months of age, Heber and Garber found an IQ gain of 33 points on the Stanford Binet, the mean IQ of the experimental group being above 125. Critical evaluation of this project is difficult since little information about the project has appeared in the professional literature.

The Mama Lere Teaching Home for deaf children under 3 years of age is a project in Nashville (Horton, 1976). On the assumption that early identification and intervention have tremendous pay-off in habilitation and normalization of hearing impaired children, the above project was implemented. The program concentrated on parent instruction involving demonstration teaching in the child's natural environment, intense audiologic monitoring of the child's hearing and use of hearing aids. A basic premise of the program was that the people most important to a young child are his mother and father, and the place most important to him is his home. Further, that very early detection and early intervention maximize the child's opportunities. The main objectives of the program were:

1) to teach parents to optimize the auditory environment of their child.
2) to teach parents how to talk to their child.
3) to familiarize parents with the principles and stages and sequences of normal language development, and to apply this

frame of reference in stimulating their child.

4) to teach parents the strategies of behaviour management.
5) to supply affective support to aid the family in coping with their feelings about their child, and the stresses that a handicapped child places on the integrity of the family.

The positive effects of the early intervention program, including the early use of hearing aids before age three years, were reflected in the children's ability to express themselves in spoken language more like their normal hearing peers than their deaf peers who had not had the benefit of early detection and intervention. (Liff, 1973)

These studies demonstrate the marked effect of early social intervention in maximizing the potential of a handicapped child.

CONCLUSIONS

The handicapped child is prevented from experiencing normal socialization because of physiological, psychological and social limitations. While the former foster an inhibiting effect in the handicapped child himself, the latter evoke negative reactions from the non-handicapped in the environment. Sheridan (1975) has stated that the young handicapped children in our culture are less likely to receive good child care than non-handicapped children. He cites the fact that children culturally labelled deviant are more likely to receive poor care than children labelled normal--as evidenced by the high number of handicapped children given up for adoption and permanent institutionalization. The problem is attributed to the child and not to the social environment.

Problems arise in the socialization of the handicapped child. Such problems include dependency, identity, sex role, exclusion and segregation as well as stigma and prejudice. Further, parents, peers, siblings, and other significant adults in the environment contribute to the difficulties of socializing the handicapped child.

Recent attempts to intervene in the early socialization of the handicapped child through parent preschool programs before the age of at least three years and preferably one year, have shown encouraging results. Further research is needed concerning the social consequences of a handicap for a child. What factors increase or decrease stigma? Are preschool parent programs before one year of age the best approach for all handicapped children? Are there equally effective alternatives? Results from such studies would make a valuable contribution not only to the improved social development of handicapped children but also to the socialization process of all children.

Having stressed the need for further research, the writer would emphasize that:

> "Progress does not wait upon research effort alone. Existing values, concepts and factual information can go far in relieving suffering, in aiding social and psychological rehabilitation, if only they applied more genuinely and generally in the ordinary affairs of life as well as among the many special enterprises that society as a whole needs to undertake.'
>
> Wright, 1960.

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